Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

FONDREN ORTHOPEDIC GP LLP
7401 SOUTH MAIN STREET
HOUSTON TEXAS 77030

Respondent Name
FARMINGTON CASUALTY CO

Carrier's Austin Representative
Box Number 05

MFDR Tracking Number
M4-13-1680-01

MFDR Date Received
March 4, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It appears that the carrier is utilizing the 4 digit zip code directory instead of the 9 digit file. The 4 digit extension is required in order to delineate the boundaries from Harris County (Locality 18) and other (locality 99). Our Katy office lies in Harris County. Please reprocess the enclosed claim for and pay accordingly."

Amount in Dispute: $8.83

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider is requesting additional reimbursement on the basis that the Carrier miscalculated the Maximum Allowable Reimbursement for the procedure at issue. The Carrier agreed that Medicare has the ZIP code for this Provider linked to the majority county, rather than the specific portion of the county containing the Provider's location, and previously issued additional reimbursement in the amount requested by the Provider. The Carrier therefore contends the Provider is not entitled to additional reimbursement."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 11, 2012	99203	$8.83	$4.18

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline reimbursement for professional medical services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - W1 – Workers compensation state fee schedule adjustment
   - Z013 – This bill has been processed correctly per the state fee schedule

Issues

1. Did the requestor submit the request timely within the one year filing deadline?
2. Did the insurance carrier reimburse the requestor per 28 Texas Administrative Code §134.203?
3. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §133.307 "(1) Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute."
   - The requestor seeks dispute resolution for CPT code 99203 rendered on June 11, 2012. The requestor initially submitted the disputed charge on September 27, 2012 under MDR M4-13-0300-01 seeking additional reimbursement in the amount of $0.20 for CPT 99203. The insurance carrier reimbursed the sought amount of $0.20 under check number 891A-0083102246; the requestor subsequently withdrew the dispute after receipt of payment.
   - The requestor submitted a second request for MDR on March 4, 2013 requesting additional reimbursement in the amount of $8.83 for CPT code 99203 rendered on June 11, 2012. The disputed charge was submitted within the one year filing deadline and is therefore eligible for review per the applicable guidelines.
2. Per 28 Texas Administrative Code §134.203 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."
   - Review of the CMS MLN Matters® Number: MM7631 states in pertinent part, "The service location information is used by physicians/practitioners/suppliers to report the name, address and ZIP code of the service location where they furnished services (e.g., hospital, clinic, or office) and is used by contractors to determine the applicable 'locality' and Geographic Practice Cost Index (GPCI)-adjusted payment for each service paid under the MPFS."
   - The zip code indicated in box 32 helps identify the applicable locality to arrive at the MPFS. The CMS-1500 documents in box "32. Service Facility Location Information" the following: "Fondren Orthopedic GP LLP, 23920 Katy Freeway, #400 Houston Texas 77494-1341." The requestor seeks additional reimbursement for disputed CPT code 99203 requesting additional payment for services identified in box 32 as rendered in "Houston, Texas". Refer to box 32 of the CMS-1500
3. Per 28 Texas Administrative Code §134.203 "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. . ."
   - The Medicare physician fee schedule for CPT code 99203 rendered in "Rest of Texas" (zip code 77494 in Katy, Texas) is $102.43 with a Medicare conversion factor of $34.0376. The division conversion factor is $54.86, the Division fee reimbursement is $165.09. The insurance carrier previously reimbursed the amount of $160.91 minus fee guideline amount of $165.09 = $4.18, therefore the requestor is entitled to an additional payment of $4.18.
4. Review of the submitted documentation finds that the requestor is entitled to additional reimbursement in the amount of $4.18.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $4.18.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $4.18 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		August 30, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.